

AMERICAN LEGACY FOUNDATION® COMMENTS
REGARDING HEALTHY PEOPLE 2010 TOBACCO USE OBJECTIVES IN
PREPARATION FOR CREATION OF HEALTHY PEOPLE 2020 OBJECTIVES

Pursuant to the request for public comments, the American Legacy Foundation (“Legacy”) is pleased to submit these comments on the Healthy People 2010 objectives relating to tobacco use in order to inform the development of objectives for Healthy People 2020.

Legacy’s comments are divided into two sections:

- The first addresses issues currently addressed in the 2010 Healthy People objectives.
- The second recommends new objectives not included in the 2010 objectives.

Please note that these comments focus on particular areas within Legacy’s expertise; they do not address all of the tobacco related issues which could be included in the Healthy People 2020 objectives.

Legacy is a national, independent public health foundation created in 1998 out of the landmark Master Settlement Agreement (“MSA”) between the tobacco industry, 46 state governments and five U.S. territories. Our mission is to build a world where young people reject tobacco and anyone can quit. Legacy does not lobby or take positions on specific legislation. Our programs include:

truth® - A national youth smoking prevention media campaign responsible for preventing approximately 450,000 youth from beginning to smoke from 2000 through 2004.

EX® - An innovative smoking cessation public education campaign designed to help smokers “re-learn” life without cigarettes.

Research Initiatives – Examining the various causes and effects of tobacco use in the United States.

Outreach to Priority Populations – Priority Populations Initiatives and grants provide critical interventions using methods that are culturally competent and tailored for the specific needs of communities disproportionately affected by the toll of tobacco.

I. Comments on Current 2010 Objectives

A. Objective 27-3. Reduce the initiation of tobacco use among children and adolescents. Simply *reducing* the initiation of tobacco use by children and adolescents is not an adequate objective for the Healthy People 2020 goals. Nearly eighty percent of smokers begin before the age of 18.¹ Accordingly,

preventing youth smoking must be an essential element of the effort to end the tobacco epidemic. This objective should be reframed to *eliminate* entirely the use of tobacco by anyone under the age of 18.

B. Objective 27-8. Increase insurance coverage of evidence-based treatment for nicotine dependency. This objective should be reframed from simply *increasing* insurance coverage for evidence-based treatments to *assuring* coverage of these treatments in *all* public and private health insurance programs. In addition, barriers to coverage such as requirements for prior authorizations, deductibles and co-pays, should be eliminated. More specifically:

1. Medicare and Medicaid should be expanded to cover behavioral counseling and both prescription and over the counter medications for all eligible smokers. Currently Medicare only covers counseling services for people who have a tobacco-related illness or are taking a medication affected by tobacco use. Further, Medicare covers prescription but not over-the-counter smoking cessation medications.² While about one third of adult Medicaid recipients smoke, a far higher percentage than found in the general population, Medicaid coverage of smoking cessation treatments and medications remains extremely limited. This is in spite of the fact that smoking-related diseases cost billions of dollars in Medicaid expenditures.
2. Expanding coverage for effective cessation treatments under employer-sponsored health plans is both practical and affordable. Expert actuaries have estimated that adding top quality smoking cessation services to a health plan would cost only 45 cents per covered employee per month, or \$5.40 per year.³ Savings per quitter would amount to \$213 in the first year and \$1096 in the fifth year.⁴ These savings would be achieved from lower rates of disease such as, stroke, coronary heart disease and adult pneumonia among smokers and lower rates of low birth weight babies and childhood ear infections among smokers' children.⁵ Increasing cessation rates would also lower the high costs of lost productivity due to tobacco-related disease. Services can be delivered through traditional health insurance coverage as well as through wellness and Employee Assistance Programs.

C. Objective 27-12. Increase the proportion of worksites with formal smoking policies that prohibit smoking or limit it to separately ventilated areas. We strongly support the objective of increasing the number of smoke-free workplaces, a proven-effective tool in both protecting non-smokers from second hand smoke as well as assisting with cessation. However, the suggestion that separately ventilated areas may be an acceptable alternative to an entirely smoke-free workplace should be dropped from this objective. The Surgeon General has found that completely eliminating smoking in indoor spaces is the only way to fully protect nonsmokers from exposure to secondhand smoke. All smoking must

be eliminated; separating smokers from non-smokers, cleaning the air, mechanical air exchange and ventilating buildings does not provide adequate protections from secondhand smoke exposure.

In addition, we recommend clarifying that this objective refers to smoke-free workplaces only and does not endorse “smoker-free” workplaces, i.e., those which prohibit the employment of smokers even if they do not smoke on the job. While, to be sure, employee smoking results in significant health care costs as well as lost productivity, we do not believe that refusing to hire smokers is sound policy for several reasons. First, smoking is an extremely addictive behavior almost always begun during a smoker’s teen years. Second, such policies would disproportionately affect low-income and low-education workers – groups who smoke at the highest rates. Third, smoking is far from the only cause of additional health care and productivity costs. Fourth, smoking is rarely, if ever, a job-related qualification. Finally, denying employment to smokers could also deny them access to job-related health care benefits.

D. Objective 27-17. Increase adolescent’s disapproval of smoking. Based on recent peer-reviewed research, this objective should be expanded to also increase adolescents’ disapproval of the tobacco industry. Research has shown that industry manipulation is one of the most effective strategies for denormalizing smoking and decreasing cigarette consumption.⁶ Studies suggest that youth prevention campaigns that promote anti-industry attitudes are significantly more effective in reinforcing realistic tobacco use norms than campaigns that show role-model teens stating their commitment to not smoking, by associating images of rebelliousness with independence from the tobacco industry. Such campaigns are consistent with social norms theory, which holds that norms corrections are generated by providing information without using directive messages that tell youth what to do, suggesting that shifting teen perceptions of smoking prevalence will in turn decrease teen smoking prevalence.⁶ The introduction of an anti-industry media campaign has been found to dramatically increase anti-industry attitudes and non-smoking intentions.⁷ Further, it has been shown that fostering negative attitudes toward the tobacco industry can prevent tobacco use among adolescents.⁸ Anti-industry strategies have also been found to be successful in conjunction with some other strategies, such as the introduction of the idea of addiction, or the difficulty of cessation.⁶

E. Objective 27-21. Increase the average Federal and State tax on tobacco products. Increasing tobacco taxes remains an important objective which will both decrease consumption and raise funds which can be used for tobacco control. However, it is not adequate to focus only on “average” taxes since differentials in taxes between types of tobacco products can influence consumers’ choices as well as tobacco industry marketing strategies. As a result, the objective should be expanded to also call for tax parity between different types of tobacco products and particularly between cigarettes, little cigars, cigarillos and cigars. Historically, taxes on cigars have been lower than those on cigarettes even though, just like cigarettes, cigars cause lung, oral, laryngeal, and esophageal

cancers and increase the risk of chronic obstructive pulmonary disease (COPD). Consumption of little cigars (which resemble cigarettes) and “cigarillos” (which are slightly larger) has been increasing at an alarming rate.⁹ These increases are frequently attributed to increases in taxes on cigarettes which have made cigars relatively less expensive. While the federal tax rate on little cigars was recently brought in line with that of cigarettes, the tax on cigarillos and large cigars remains disproportionately low. Consequently, an incentive persists for manufacturers to expand production of these products to take advantage of the lower tax rate.

II. Proposed New Objectives

A. Include an objective specifically dedicated to reducing tobacco-related health and prevalence disparities. While Healthy People 2010 addresses a number of tobacco-related health and prevalence disparities, it does not include an objective specifically focused on reducing these disparities based on race/ethnicity, socio-economic status, educational attainment and other factors. Because these disparities contribute to significant disparities in health in general, we urge the inclusion of an objective specifically focused on the elimination of disparities in Healthy People 2020.

B. Support a national, evidence-based, independent and well-funded youth prevention media campaign. Because nearly all smokers begin smoking in their teens, preventing young people from ever starting to smoke is one of the most effective ways to stem the tobacco epidemic. Public-health driven media campaigns have proven highly effective in reducing youth smoking. In fact, peer-reviewed research has demonstrated that the American Legacy Foundation’s truth[®] campaign, which debuted in 2000, kept 450,000 young people from starting smoking just in its first four years and saved as much as \$5.4 billion in medical care costs in its first four years.^{10, 11} This type of proven campaign could save significantly more lives and health care dollars in the future.

Campaigns must be adequately funded. An effective youth-targeted media campaign is not inexpensive to run. This is especially true since it must counter the tobacco industry marketing juggernaut, fueled by \$13 billion in annual expenditures. While it is not necessary to match industry expenditures dollar for dollar, it will take at least \$100 million per year to mount an optimally effective national campaign including mass media a grassroots presence and a rigorous evaluation component.¹¹ Because it is essential to carefully target advertisements to the intended audience, public service announcements, which are run at the discretion of the broadcaster, do not present a viable alternative to paid media.¹² The national media campaign should be funded by the federal government and amplified at the state and local level.

C. Support a national, public-health driven media campaign to educate smokers and their families about how to quit smoking and how to access proven-effective services that will help them. A national, public-health driven

media campaign is essential to educate smokers and their families about how to quit smoking and how to access proven-effective services that will help them.¹³ Initial results from the American Legacy Foundation's EX[®] campaign, the only national, independent media campaign promoting smoking cessation in the U.S. in nearly forty years, confirm the importance and efficacy of a national media campaign.¹⁴ A national campaign offers the most efficient way to spend limited media dollars since it is much less expensive to purchase media on a national as opposed to a regional, state or local basis. A national campaign will also achieve cost-savings by avoiding the cost duplication and inefficiencies inherent in the implementation and evaluation of fifty separate state campaigns. Based on our experience with EX as well as our national youth tobacco prevention campaign, truth[®], an effective national media campaign to promote adult cessation, including a strong evaluation component, will cost about \$100 million a year.¹¹ Because it is much less expensive and more efficient to develop and evaluate a campaign and purchase media on a national as opposed to a regional, state or local basis, this estimate is considerably less than the CDC recommendation for media expenditures which is based on separate state campaigns¹⁵. The national media campaign should be funded by the federal government and amplified at the state and local level.

D. Increase smoking cessation interventions by a broad spectrum of health care providers. Health care providers, including physicians, nurses, psychologists, dentists, counselors and others, can make an important contribution toward increasing quit rates – and protecting the health and lives of their patients. All clinicians should screen patients for tobacco use, strongly advise smokers to quit and provide at least brief behavioral counseling and medication advice. Clinicians should refer smokers to other proven-effective services, including more intensive counseling, when they cannot effectively provide the services themselves.¹⁶ While even minimal interventions of less than three minutes can increase quit rates, the evidence shows that more intensive interventions are more effective. The experts recommend a total of 90 minutes of counseling, spread across at least four sessions.¹⁷

The emphasis is to be placed on reaching, educating, and motivating smokers to quit, as well as ensuring access to the full range of comprehensive evidence-based treatments available, receiving the appropriate type and level of treatment, and providing follow up with smokers to prevent relapse. It is especially critical to tailor cessation education and information about access to intervention, and to enforce policies that support those smokers of lower socioeconomic and educational backgrounds who also tend to be under- or un-insured.¹⁸ A recent study shows that education and income are negatively associated with successful quitting, particularly in the long term.¹⁹ Furthermore, because several studies indicate that African American and Hispanic smokers are less likely than white smokers to be advised by a physician to quit, particular attention must be paid to eliminating disparities in physician advice by race/ethnicity^{20, 21, 22}

E. Eliminate smoking imagery from youth-rated movies and other youth media, including video games. Research shows that smoking in youth-rated films has a powerful impact on youth smoking initiation, influencing 200,000 children and adolescents to take up smoking each year.²³ A recently published report of the National Cancer Institute concludes that exposure to smoking in the movies promotes adolescent smoking initiation²⁴ and other studies have found that exposure to smoking in the movies is causally related to over one-half of all adolescent smoking initiation.²⁵ Many organizations, including Legacy, have endorsed four principles designed to accomplish this goal. They are:

1. Require strong anti-tobacco ads that are evidence-based to run before any film with any tobacco presence, regardless of its rating;
2. Stop brand identification in movies through the depiction of identifiable packs of cigarettes, billboards, or other forms of tobacco brand identification;
3. Certify no pay-offs through a statement in the movie credits that nobody on the production received anything of value in exchange for using or displaying tobacco; and
4. Rate all new movies with smoking “R”, unless the movie clearly and unambiguously reflects the dangers and consequences of smoking or if it accurately depicts the behavior of an actual, historical figure.

These principles enjoy strong public support; 80% of U.S. adults agree that smoking in movies can influence young people to smoke; 70% agree with an R-rating for movies with smoking; and more than 60% want tobacco branding out of movies.²⁶

F. Monitor public knowledge, beliefs and attitudes related to tobacco use. Research has shown that knowledge, beliefs and attitudes about tobacco use mediate people’s behavior surrounding smoking initiation and cessation, and influence support for tobacco-related policies. Lower knowledge of smoking risk and higher use of tobacco has been found to occur in vulnerable populations and in the regions of the country with the highest tobacco production and the highest tobacco-related mortality.²⁷ Those who are willing to try various cessation methods, and have beliefs about the consequences of smoking and the benefits of quitting have been found to be more easily able to quit.²⁸

G. Develop and maintain a strong national surveillance and monitoring system that tracks the marketing and changing tactics of the tobacco industry. Leading tobacco research scientists have called for establishing a national surveillance system to monitor the tobacco industry.²⁸ This comprehensive system can provide a mechanism to inform public health scientists and practitioners regarding new tobacco industry products, and monitor the specific marketing claims made on behalf of the tobacco industry. This objective can help ensure that the public health and tobacco control communities, as well as consumers, are fully informed in a timely manner about new tobacco industry products as well as the validity of the potential claims of safety and efficacy.

¹ Calculated based on data in Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2006 National Survey on Drug Use and Health (NSDUH)*, 2007. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

² Centers for Medicare and Medicaid Services. Smoking Cessation – Overview. Available at: <http://www.cms.hhs.gov/SmokingCessation/>. Accessed 23 April 2009.

³ Fitch K, Iwasaki K, Pyenson, B, Covering Smoking Cessation as a Health Benefit: A Case for Employers, Milliman, Inc. 2006. Available at http://www.americanlegacy.org/PDFPublications/Milliman_report_ALF_-_3.15.07.pdf.

⁴ Fitch, et al. 2006.

⁵ Fitch, et al. 2006.

⁶ Goldman LK, Glantz SA. Evaluation of Antismoking Advertising Campaigns. *Journal of the American Medical Association* 1998; 279:772-7.

⁷ Niederdeppe J, Farrelly MC, Hersey HC, Davis KC. Consequences of dramatic reductions in state tobacco control funds: Florida, 1998-2000. *Tobacco Control* 2008; 17:205-10.

⁸ Thrasher JF, Niederdeppe JD, Jackson C, Farrelly MC. Using anti-tobacco industry messages to prevent smoking among high-risk adolescents. *Health Education Research* 2006; 21(3): 325-37.

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¹⁰ Farrelly MC, Nonnemaker J, Davis KC, Hussin A. The Influence of the National truth campaign on smoking initiation. *American Journal of Preventive Medicine* 2009; 36(5):379-84.

¹¹ Holtgrave DR, Wunderink KA, Vallone DM, Heaton CG. Cost-utility analysis of the National truth campaign to prevent youth smoking. *American Journal of Preventive Medicine* 2009; 36(5):385-8.

¹² Hornik, R. (ed.). (2002). *Public Health Communication: Evidence for Behavior Change*. Lawrence Erlbaum Associates, Publishers. New Jersey, London.

¹³ IOM at 235-237.

¹⁴ Vallone DM, Duke JC, Mowery PD, McCausland KM, Xiao H, Costantino JC, Asche ET, Allen JA., The impact of 'EX': Results from a pilot smoking-cessation media campaign. Forthcoming in *American Journal of Preventive Medicine*.

¹⁵ The CDC recommendation for "Health Communications Interventions" is separate from its recommended expenditures for cessation interventions discussed above.

¹⁶ Fiore et al. 2008. Chapter 6. Parts A1 and A3.

¹⁷ Fiore et al. 2008. Chapter 6. Part A2.

¹⁸ Adams PF, Lucas JW, Barnes PM. Summary health statistics for the U.S. population: National Health Interview Survey, 2006. *Vital Health Statistics* 10 2008; January(236):1-104.

¹⁹ Fagan P, Shavers VL, Lawrence D, Gibson JT, O'Connell ME. Employment characteristics and socioeconomic factors associated with disparities in smoking abstinence and former smoking among U.S. workers. *Journal of Health Care for the Poor and Underserved* 2007; 18(4 Suppl):52-72.

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